# Spring To Life Counseling, LLC

## CHILD PSYCHOSOCIAL HISTORY

Name: _____ Age: _____ DOB: _____

**I. Current parental relationship status**

**II. History of parental relationship status**

**III. Family of Origin**

**IV. Current Support Network (i.e. friends)**

**V. Childhood History**

**a.** Trauma(s):

**b.** Illness(es):

**c.** Other(s):

**VI. Suicidal Assessment**

**a.** Thoughts of Suicide? (recent and past):

**b.** Attempt(s):

**c.** Self-Harm:

**d.** Thoughts of harming others:

**VII. Interests/Hobbies**

**VIII. Employment history, if any?**

**IX. Education history**

**X. Ethnic/Cultural Identity**

**XI. Physical Health**

**XII. Alcohol/Drug Usage**

a. **Treatment History**

**XIII. Prescription Medication**

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## XIV. Treatment History for presenting concerns

**If you have had outpatient treatment:**

Clinic's name: _____ Dates of Service: _____

Therapist's name: _____

**If you have had inpatient hospitalization:**

Hospital name: _____

Dates of Service: _____ Therapist name: _____

If yes to either, please explain: _____
_____
_____
_____

## XV. Treatment History for Mental Health

**If you have had outpatient counseling for mental health:**

Clinic's name: _____ Dates of Service: _____

Therapist's name: _____

**If you have had inpatient hospitalization for mental health:**

Hospital name: _____

Dates of Service: _____ Therapist name: _____

If yes to either, please explain: _____
_____
_____
_____

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## XVI. OTHER INFORMATION

**What do you consider to be your strengths?**

**What do you like most about yourself?**

**What are effective coping strategies that you have learned?**

**What are your goals for therapy?**

Client Signature _____ Date _____

Therapist Signature _____ Date _____